Assumption Life

Extension of Disability
Claimant's Statement

Part A

First name : _____ Last name : _____

Policy number : _____ Telephone number : _____

Address : _____

1. **Since the last medical report :**
   a) How many medical consultations have you had? _____
   b) Name all physicians consulted : _____
   _____
   c) Have you been hospitalized? ☐ Yes ☐ No
   If yes, where and when? _____

2. **Are you presently performing any type of work, even part-time, for which you receive any form of remuneration?** ☐ Yes ☐ No
   If yes, since when? _____
   Nature of work: _____

3. **Do you expect to return to work** ☐ Yes ☐ No
   If yes, when? _____

4. **Describe any limitations or restrictions which prevent you from working:** _____
   _____
   _____

5. **Describe your present symptoms and the changes in your condition since your last report:** _____
   _____
   _____

6. **Have you applied for, are you receiving or are you eligible to receive any disability benefits under the following plans?**

Group Disability Plan	☐ Yes	☐ No	Give Details: _____
Canada/Quebec Pension Plan	☐ Yes	☐ No	Give Details: _____
Other Plans	☐ Yes	☐ No	Give Details: _____

Declaration and authorization

I hereby certify that the information given above is true and authorize the release of any information in respect of this claim to the insurer and authorized representatives.
A copy of this authorization shall be as valid as the original.

_____ _____

Date Signature of Claimant

Part B must be completed by our treating physician.

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 506-853-6040/1-800-455-7337 Fax 506-853-5459

Extension of Disability
Physician's Statement

Part B

First name : _____ Last name : _____ Date of birth : _____

The patient is responsible for securing this form and for any charges for its completion.
This form may be mailed directly to the Insurer or given to the patient at the physician's discretion.

1. Diagnosis

a) Primary : _____

b) Secondary (if applicable) : _____

_____

2. Present condition (Please include results of current X-rays, E.K.G. or any other special tests and copies of consultation reports)

a) Describe complications, recent surgery or new independent condition(s) which are contributing to the duration of disability:

_____

b) Has patient : ☐ recovered ☐ improved ☐ not improved ☐ retrogressed

c) Patient is : ☐ ambulatory ☐ bed confined ☐ house confined ☐ hospital confined

d) Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof? ❑ Yes ❑ No

3. Cardiac (if applicable) :

a) Functional Capacity : ☐ Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

b) Blood Pressure (latest visit) : _____/_____
Systolic/diastolic

4. Current treatment :

a) If drugs prescribed, names and dosages : _____

_____

b) Other treatment : give details _____

_____

5. Extent of disability

a) Is patient now totally disabled for regular occupation ? ❑ Yes ☐ No Other occupation? ❑ Yes ❑ No

b) If ''No'', when was patient able to resume work for regular occupation? _____ Other occupation? _____

c) If ''Yes'', when should patient be able to resume work for regular occupation? _____ Other occupation? _____

d) If indefinite, the estimated number of additional weeks/months before patient's return. _____

6. Physical limitations ❑ Yes ❑ No

If ''Yes'', what are the limitations? _____

_____

_____

Are these limitations : ☐ temporary, duration _____ ☐ permanent?

7. Notes

_____

_____

_____

Declaration and authorization

I hereby certify that, to the best of my knowledge, the answers given above are full and true.

Physician's name : _____ Telephone number: _____

Address: _____ Fax number: _____

Physician's signature: _____ Date: _____

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